DOCUMENT RESUME

ED 335 611 CG 023 604

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TITLE Family World View, Parent Emotion Management and Adolescent Health.
INSTITUTION California Univ., San Francisco. Div. of Family and Community Medicine.
SPONS AGENCY Tucson Community Foundation, AZ.
PUB DATE Apr 91
CONTRACT NIMH-38468
NOTE 19p.; Paper presented at the Society for Research in Child Development Biennial Meeting (Seattle, WA, April 18-21, 1991).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; *Child Health; *Family (Sociological Unit); *Family Attitudes; Hispanic Americans; *Nuclear Family; *Well Being; Whites

ABSTRACT

This study hypothesized that relatively specific aspects of family life are associated with relatively specific aspects of health and well-being, and that the pattern of these associations varies as a function of certain primary characteristics of family members, such as gender, role, and generation. To test these hypotheses, data were collected from 225 two-parent white or Hispanic families of adolescents. The adolescent sample from the families consisted of 141 males and 137 females. Subjects completed measures of adolescent health, family world view, and couple emotion management. Data were analyzed to determine patterns of association between the four family world view indices and adolescent health, and between the three couple emotion management ratings and adolescent health for males and females. The results revealed that both family world view and couple emotion management were significantly associated with those aspects of adolescent health that unfold inside the family. Family coherence was linked with emotional and physical well-being for males and with emotional well-being and low anxiety scores for females. Striking differences were found in both strength and pattern of family and health associations between adolescent males and females. It appeared that the sense of feeling close and involved with family, especially the parents, was important for female adolescents in terms of their reported health and well-being. Family domains were significantly associated with aspects of adolescent health. (NB)

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# FAMILY WORLD VIEW, PARENT EMOTION MANAGEMENT AND ADOLESCENT HEALTH

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This research is supported by NIMH Grant #38468.

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CG023604

Paper presented at the Society for Research in Child Development Meetings, Seattle, Washington, April, 1991



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In this presentation we provide a glimpse into an ongoing program of family and adolescent health research. To reach our goal of modeling the underlying mechanisms of family and adolescent health relationships, we ask the following question: Of the two major competing approaches to conceptualizing family and health relations, what we here call the Big G view as contrasted with what we call the differentiated view, which best describes these relationships in our community-based sample?

The Big G view seeks to find and then to confirm across all persons and all outcomes the premier quality of family relations that produces and sustains health, and protects family members from all sorts of negative health consequences, from low birth weight to depression, to accidents. This quality may have a number of indices, but it is the underlying factor that is thought to make the difference. However measured, this component is like the Big G factor in early intelligence research that explained the lion's share of the variance. A proponent this Big G approach in family and health theory, for example, is Antonovsky (1988). Families who score highly on a "Sense of Coherence" have members who would be expected to be good stress managers and have favorable scores on a broad range of health-related outcomes. The Circumplex Model is another example. Families with good scores on cohesion and adaptability are hypothesized to do well on a host of health

and well-being variables. We wonder, however, what if other outcomes had been chosen? Would the same Big G family measure work just as well? And further, what if another family variable had been selected? Would it have worked just as well?

With these questions in mind, the alternative view challenges the Big G position in two ways. First, opponents argue that isolating a single dimension ignores the complexity of family qualities and styles, and the differential contribution that multiple domains can make on health. Qualities of family communication or belief, for example, may have links with relatively specific but substantially different health indicators. Second, critics of the Big G view do not assume that the family affects all members in the same way. Different aspects of family life may vary in their salience by gender and generation, for example. Further, if a family performs well on the underlying Big G construct, how does one then account for variations in health-related functioning among members of the same family? A proponent of this second approach, the differentiated view, is David Reiss, whose work has repeatedly shown that different family patterns of constructing reality and relating to the wider social environment can be a strength or a liability depending upon what kind of health issue or problem is at hand.

From our reading of the literature, it appears that the majority of family and health studies either implicitly or explicitly adopt the Big G perspective, although there is no consensus on what the ultimate family quality that promotes health is. A more differentiated approach seeks instead to understand several circumscribed health outcomes through sampling a variety of well-defined family qualities. Patterson's work on conduct disorders, Hauser's work on adolescent diabetes, Heatherington's work on divorce and remarriage, and the Cowans' work on the birth of a first child are examples of this approach.

Our general hypothesis, which flows from this more complex alternative, is that relatively specific aspects of family life are associated with relatively specific aspects of health and well-being. Further, we hypothesize that the pattern of these associations varies as a function of certain primary characteristics of family members, such as gender, role, and generation.

This relatively straightforward research question presents a considerable challenge. It suggests the need to map the terrain of family and health relationships across several large areas of family life and across several areas of health, for both males and females, and for more than one generation of family members (Fisher, Terry, & Ransom, 1990). Today, we will illustrate the complexity of family and health relationships by reporting associations between two broad

domains of family variables, Emotion Management and World View, with six indices of adolescent health and well-being, separately by gender. Our plan is to sample broadly from each of the two family domains and the health domain, to reduce the number of variables in ways that conform with the pattern of each within-domain variable configuration, and then to determine the relative specificity of family and adolescent health linkages. Because of the number of steps in this process and the number of variables involved, we will present this material here only in its distillate form.

Two words of caution are warranted at the outset. First, these data are cross-sectional and we cannot assert causality from family to health or from health to family. Second, these data are based on a community-based sample of white and Hispanic two-parent families, although many are step-parents. The data may not generalize to referred or clinical families, to single parent families, or to families of other ethnic and cultural backgrounds.

## METHODS

### Subjects

Two hundred and twenty-five families were recruited from a central California community of 500,000, using a random and anonymous telephone screening procedure. Families were eligible to participate if the telephone screen indicated (1) adult heterosexual cohabitation of at least three years, (2) an adolescent between the ages of 12 and 18 in the home, (3)

Anglo or Hispanic ethnicity, (4) all members educated in the U.S., and (5) no family member left or returned home in the last three months.

As in most assessment intensive studies, social class was negatively skewed, although classes I through IV were well represented. All but one couple were legally married, average length of marriage was 17 years, and 40% of families had a step-parent. Combined family income was $44,350, and 98% of husbands and 70% of wives were employed outside the home at least part-time.

The adolescent sample was comprised of 278 13 to 18 year olds, 141 males with a mean age of 15.1 years, and 137 females with a mean age of 15.5 years. There were roughly equal numbers of males and females at each age.

**Scales and Measures**

From the family and health literature, we identified four broad family domains with documented associations with health. We will report data from two of these domains, family World View and couple Emotion Management, and both domain's association with adolescent health.

SLIDE NUMBER 1 ABOUT HERE

Adolescent Health. This table lists 12 self-report adolescent health scales and their sources. Most were extracted from the RAND Health Assessment Questionnaire (Ware, 1986), but others were added to provide a broad

sampling of the health construct. Each displays good psychometric properties.

Using non-metric multidimensional scaling analyses (MDS) and principal components analysis (PCA), these 12 scales were grouped as shown into six indices. We were careful to observe both the metric and non-metric properties of the data, and these indices represent well the conceptual space covered by these scales.

SLIDE NUMBER 2 ABOUT HERE

Family World View. Family World View refers to the beliefs, sentiments, attitudes, and perspectives that frame the family's approach to the world. Using six scales from this relatively under-researched area of family life, we again employed MDS and PCA to create indices that adequately reflect the interrelationships among the scales. Family Coherence overlaps but is not identical with Antonovsky's "Sense of Coherence" construct. It is an index based on three scales: family Optimism, family Chance, and family Powerful Others Locus of Control. It refers to an optimistic view that the family can manage what life has to offer. Life Engagement refers to a positive family attitude for engaging in new experiences, taking some risks, preferring difference to consensus, and preferring variety to sameness.
Child-Adult Separation refers to opinions concerning the separation of children and adults in the family (e.g., Parents often go out without the children. We believe that

parents must have a life separate from the children.) Last, Child-Centeredness reflects the belief that family life should revolve around the children.

SLIDE NUMBER 3 ABOUT HERE

Couple Emotion Management. Ratings of adult couple interaction assessed the ways in which emotion is demonstrated and responded to, together with the affiliative tone of the family. Global ratings of couple interaction and counts of specific behaviors, scored from the video-tape by family clinicians, were used to assess several aspects of spouse interaction. In this report, we include three global ratings that assess the affiliative tone of the couple. Couple Supportiveness, Emotional Distance, and Hostility each were rated from high to low on a behaviorally-anchored, five-point scale.

**Data Analytic Strategy**

Our aim was to observe the patterns of association between the four family World View indices and adolescent health, and between the three couple Emotion Management ratings and adolescent health for males and females. Hierarchical regression was used, with family social class entered first and the variables from either family World View or couple Emotion Management entered as a set in a second step. Separate equations were run for each of the six adolescent health indices for males and for females.

**RESULTS**

SLIDE NUMBER 4 ABOUT HERE

**World View**

In this figure we represent with a line those multiple regression equations in which the second step, containing the family variables, accounted for a statistically significant portion of the variance in the dependent adolescent health index, over and above the effects of social class, entered as the first step. Above the line is the $R^2$ for the set and the p. value for the set's F ratio. Below the line is the individual scale's T value together with the probability estimate for that T statistic. As you can see in the upper figure, as a group the four family World View variables were significantly associated with both male adolescent Emotional Health and Physical Health, accounting for about nine per cent of the variance in both equations. Family Coherence was the only scale reaching significance for the adolescent males.

Four equations reached significance for the female adolescents. The group of family World View indices were significantly associated with Emotional Health, Anxiety, Physical Well-Being and Risk Behavior, over and above the effects of social class. Similar to males, family Coherence was positively associated with female adolescent Emotional Well-Being, but Coherence also was negatively associated with Anxiety. Further, unlike, males, female adolescent appraisals of family Child-Adult Separation were positively

associated with both Anxiety and Risk Behavior and negatively associated with Physical Well-Being.

SLIDE NUMBER 5 ABOUT HERE

**Emotion Management**

The three Emotion Management ratings as a set were significantly associated with two male adolescent health indices in the expected direction: Anxiety and Risk Behavior. Of the three Emotion Management ratings, Emotional Supportiveness was negatively associated with male adolescent Anxiety and couple Hostility was positively associated with Risk Behavior.

For female adolescents, the group of couple Emotion Management ratings also was significantly associated with health. Unlike their male counterparts, however, the Emotion Management variables were correlated with Emotional Well-Being and nothing else. Further, two of the three ratings, couple Emotional Support and Emotional Distance, attained significant associations in the Emotional Well-Being equation.

## DISCUSSION

These preliminary results speak to our guiding questions in clear terms. Three findings stand out. First, both family World View and couple Emotion Management were significantly associated with those aspects of adolescent health that unfold inside the family. Close friendships and behavior at school refer to arenas outside the family and

these were not associated with adolescent appraisals of family World View or parent Emotion Management. Second, Family Coherence emerged as an important construct for both males and females. It is linked with both emotional and physical well-being for males and with emotional well-being and low anxiety scores for females. This pattern was also found in the analysis of the parents' data (Ransom, Fisher, & Terry, in preparation). Antonovsky's coherence construct turns out to be a robust one in our study.

A particularly important finding is the striking differences in both strength and pattern of family and health associations between adolescent males and females. Adolescent females' sense of Family Coherence accounts for twice as much variance in emotional well-being, for example, as does males'. Further, Child-Adult Separation is a salient dimension for females, but it is not for males. It appears that the sense of feeling close and involved with family, especially with parents, is important for females in terms of their reported health and well-being. We note parenthetically that no direct tests for differences by gender were undertaken. Such tests are required to confirm these observational findings.

A third finding is that the family domains, measured in two modes -- self-report and observer ratings -- were both significantly associated with aspects of adolescent health. It is not surprising that adolescents' appraisals of their

families would correlate with answers to questions about their health and well-being, since both were assessed by self-report. We acknowledge a potential problem here with shared method variance. What is encouraging, however, is that parental exchanges of affect also are associated with adolescent health reports, linking two sets of variables measured in very different modes.

In closing, we interpret these exploratory data to suggest that the Big G approach in family and health research is too simplistic, as illustrated by differences in family and health linkages for adolescent males and females across different aspects of the family and different aspects of health. Gender-based social roles, role expectations, and norms expose males and females to different developmental demands, foster differential skill development for coping with family stress, and lead to different sensitivities and vulnerabilities in family and health relationships. Similar differences in family and health linkages based on gender were found between husbands and wives in earlier analyses not reported here today, and we are not surprised that these patterns were repeated for adolescents (Fisher, Nakell, Terry, & Ransom, in preparation a; Fisher, Ransom, Terry, & Burge, in preparation b; Ransom et al., in preparation).

These data remind us that the family is not a "homogenized vector" that affects all its members in the same

way. Different aspects of the family have implications for different aspects of health.

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## ADOLESCENT HEALTH INDICES AND SCALES (SELF-REPORT)

| INDEX | SCALE | SOURCE |
|---|---|---|
| Emotional Well-Being | General Well-Being | RAND |
| | Depression | RAND |
| | Self-Esteem | Rosenberg |
| Anxiety | Anxiety | RAND |
| Physical Well-Being | Health Evaluation | RAND |
| | Health Perceptions | RAND |
| | Somatic Symptoms | RAND |
| Risk Behavior | Drinking | RAND |
| | Smoking | RAND |
| School Functioning | Grades | RAND |
| | School Success | RAND |
| Close Social Relations | Social Network | Fischer & Phillips |

## FAMILY WORLD VIEW INDICES AND SCALES (SELF-REPORT)

| INDEX | SCALE | SOURCE |
|---|---|---|
| Family Coherence | Family Optimism | CFLS |
| | Family Chance Locus of Control | Levenson |
| | Family Powerful Others LOC | Levenson |
| Family Life Engagement | Family Life Engagement | CFLS |
| Child-Adult Separation | Child-Adult Separation | CFLS |
| Child-Centeredness | Child-Ceteredness | CFLS |

## COUPLE EMOTION EXPRESSION AND MANAGEMENT (RATINGS OF COUPLE INTERACTION)

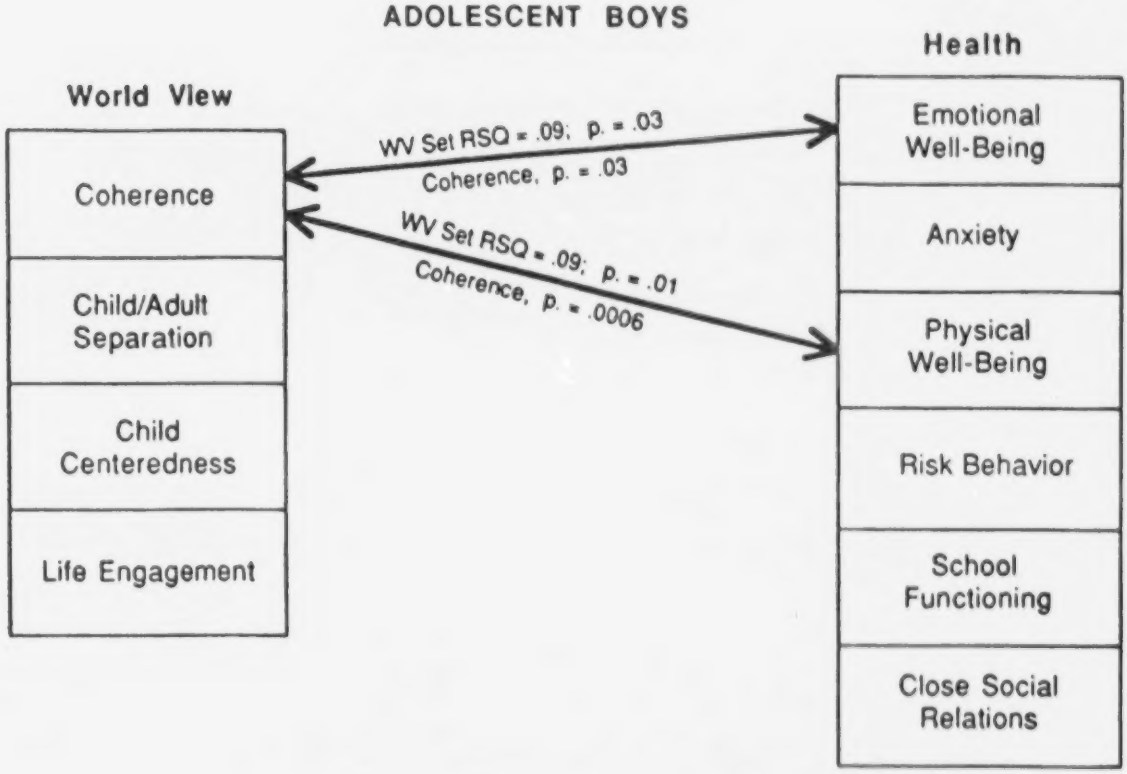
Emotional Support

Emotional Distance

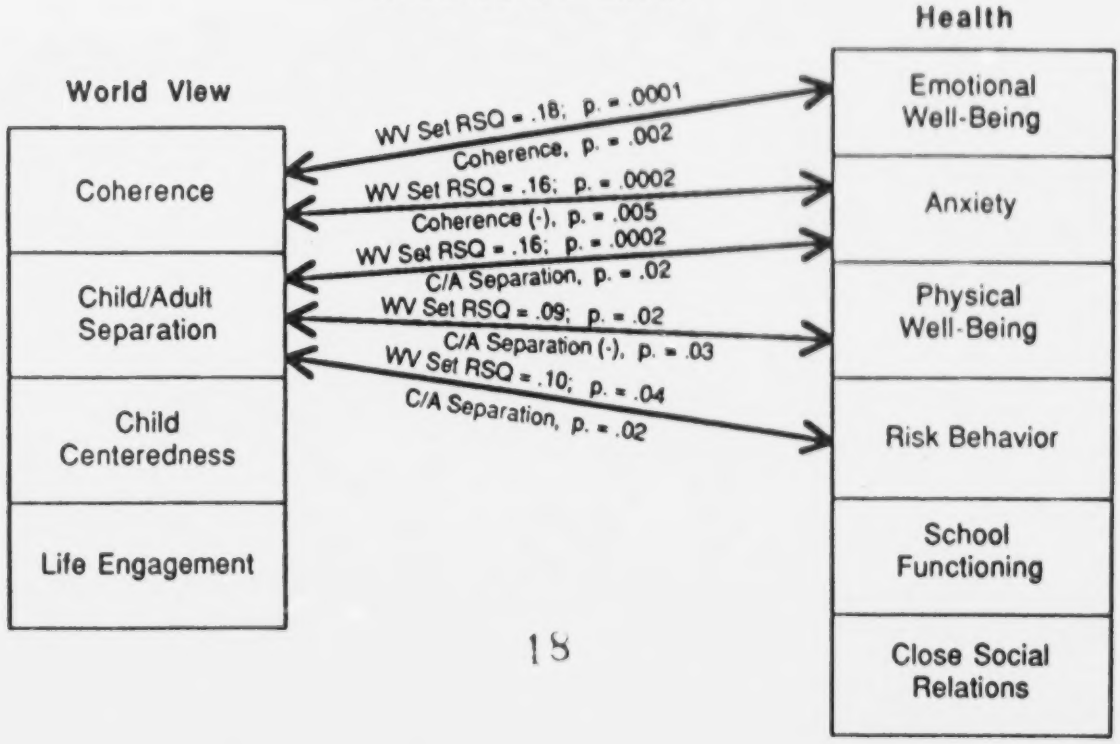
Hostility

## SIX HEALTH INDICES REGRESSED ON SET OF FAMILY WORLD VIEW SCALES

### ADOLESCENT BOYS

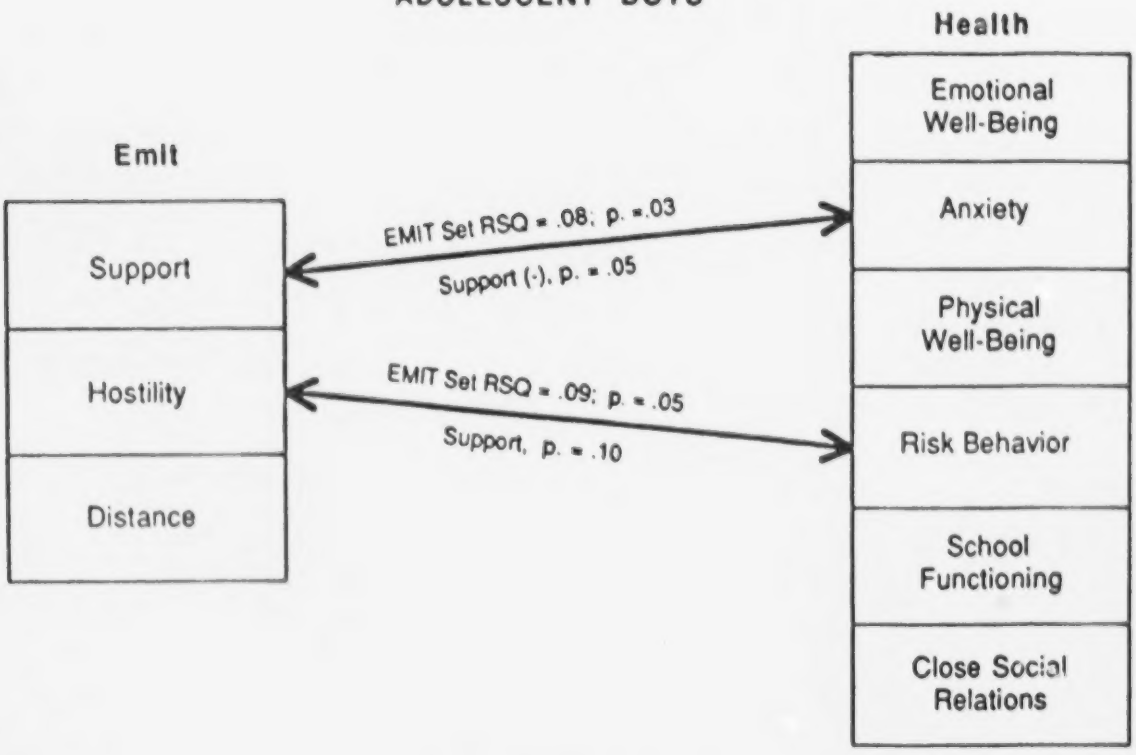



### ADOLESCENT GIRLS


World View
Coherence
Child/Adult Separation
Child Centeredness
Life Engagement
Health
Emotional Well-Being
Anxiety
Physical Well-Being
Risk Behavior
School Functioning
Close Social Relations
WV Set RSQ = .18; p. = .0001
Coherence, p. = .002
WV Set RSQ = .16; p. = .0002
Coherence (-), p. = .005
WV Set RSQ = .16; p. = .0002
C/A Separation, p. = .02
WV Set RSQ = .09; p. = .02
C/A Separation (-), p. = .03
WV Set RSQ = .10; p. = .04
C/A Separation, p. = .02

## SIX HEALTH INDICES REGRESSED ON SET OF COUPLE EMOTION EXPRESSION AND MANAGEMENT SCALES

### ADOLESCENT BOYS




### ADOLESCENT GIRLS